Office of the Administrator
P.O. Box 14464
Des Moines, IA 50306-8993

RESERVE STRENGTH
RESERVE LIFE

Dear ROA Member,

Thank you for requesting information on ROA's Group Term Life Insurance Plan. I'm pleased to send the information you requested.

As you would expect, ROA won't sponsor a plan that doesn't have competitive affordable GROUP rates. There's never been a better time to consider the ROALife Plan.

For example, a 49-year-old non-tobacco-using ROA Member is entitled to the following monthly rates:

$10.45	$20.90
for $50,000.00 coverage	for $100,000.00 coverage

Rates shown are guaranteed until October 31, 2020.

And your spouse[1] can be covered, too. In fact, many members are already taking advantage of these relatively low rates to cover their spouses[1]. Spouses[1] can apply for up to the same level of coverage as the member's life insurance amount.

And there's more...

Your membership in ROA, combined with the group purchasing power of ROA, helped secure valuable benefits for you and your family. These benefits are automatically included in your ROALife Plan – at no extra cost to you!

- **You get an exclusive Killed-In-Action Benefit**. Your loved ones will collect up to an extra $25,000.00 (or your benefit amount, whichever is less) if you're declared "killed in action" by the Department of Defense in a designated combat zone.

- **You can collect up to 50% of your ROALife benefit** (or $50,000.00, whichever is less) if you become terminally ill as defined in your Certificate with less than six months to live. You can use this "living benefit" any way you want. Your beneficiary will then receive the remainder of your life insurance benefit at your death. Receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.

(Continued...)

- **You're covered 365 days a year, wherever you are**. The only exclusion is suicide within the first year of the date your insurance or increase in insurance starts. The Accelerated Life Benefit and AD&D benefit are subject to additional exclusions.

- **You pay no premiums if you're disabled**. Your coverage will continue at no cost to you if you become continuously totally disabled for at least nine consecutive months and if your disability occurs before age 60, subject to policy provisions.

- **Term Life Emergency Benefit**. Your primary beneficiary may be eligible for an immediate death benefit of up to $5,000.00 within 24 hours of your death. This benefit is designed to help with the immediate expenses surrounding the death of a member. The remaining benefits will be paid as soon as the claim process has been completed.

- **Voya Travel Assistance Service.*** What if you or your spouse[1] is traveling (more than 100 miles from your home—even abroad) and you're in an accident, lose your passport or need other assistance? This program can help you plan your trip and deal with potential problems you may have while traveling at no additional cost to you.

Think of this as your own personal travel assistance team on-call 24 hours a day, every day, from anywhere you might be that's away from home, or even abroad!

- **Funeral Planning & Concierge Service.**** In the event of your death, your surviving spouse[1] and children (under age 26) are eligible for funeral planning assistance from trained advisors at no additional cost to you.

I need to hear from you today.

Please take a few minutes right now to review and complete the enclosed application. Then return it in the enclosed postage-paid envelope. Don't send any money now. Once your application is approved by the insurer, we will then send you a bill.

Sincerely

Anthony A. Baldus, Principal
Mercer Health & Benefits Administration LLC
ROA Insurance Plans Administrator
License #8704140

P.S. Budget-conscious group rates are just one of the reasons many ROA members and their families have taken advantage of ROALife. Please look over the enclosed information to see what your fellow members have to say.

Group Term Life Insurance underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. The group policy is sitused in the state of North Dakota and is governed by its laws. This is a paid endorsement. ROA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

Policy Form #LP08GP

*Voya Travel Assistance services provided by EuropAssistance USA, Bethesda, MD. Services are not available in OR.
**Funeral Planning and Concierge Services provided by Everest Funeral Package, LLC, Houston, TX.

[1]In Oregon, spouse includes domestic partner.

 ILI020L - ROA

Group Term Life Application

ROA RESERVE STRENGTH RESERVE LIFE

Please complete the entire application. Waiver of Premium Disability Benefit is automatically included. Please print clearly in dark ink and mail to ROA ***Group Insurance Program, P.O. Box 14464, Des Moines, IA 50306-8993, or call 1-800-247-7988, or email roa.service@mercer.com.***

Reserve Officers Association | Policy No. 31816-7

1. TELL US ABOUT YOURSELF

Member's Information *(complete this section only if applying for Member coverage on this application)*:

Name (Last, First, MI)			❑Male ❑Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	Email Address	

Spouse's Information *(complete this section only if applying for Spouse coverage on this application)*:

Name (Last, First, MI)		Name of Member	❑Male ❑Female
Date of Birth (MM/DD/YYYY)	Place of Birth	Social Security Number	
Address	City	State	Zip
Home/Cell Phone #	Work Phone #	Email Address	

Dependent Child(ren)'s Information *(complete this section only if applying for Dependent Child(ren) on this application)*:

Number of eligible children:_____ Include Name, Date of Birth (DOB), and Social Security Number (SSN) of each child below

Name_____ DOB_____ SSN_____

Name_____ DOB_____ SSN_____

Name_____ DOB_____ SSN_____

Name_____ DOB_____ SSN_____

Address	City	State	Zip	Home/Cell Phone #

	Member	**Spouse**
a) Do you currently use or have you used tobacco or nicotine products in any form in the last 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
b) Are you currently working less than 24 hours per week at your regular occupation and place of business?	❑ Yes ❑ No	❑ Yes ❑ No
c) Will any of the life insurance proposed in this application replace, discontinue or change any life insurance or annuities now in force?	❑ Yes ❑ No	❑ Yes ❑ No

If yes, please explain:_____

PLEASE COMPLETE AND SIGN END OF APPLICATION

2. SELECT YOUR COVERAGE

Member Amount (Non-Tobacco User):

❑$100,000 (M0Y1) ❑$50,000 (M0N1) ❑$25,000 (M0H1)

❑Other: $_____ *in $5,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Spouse Amount (Non-Tobacco User):

❑$100,000 (M0Y5) ❑$50,000 (M0N5) ❑$25,000 (M0H5)

❑Other: $_____ *in $5,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Member Amount (Tobacco User):

❑$100,000 (T0Y1) ❑$50,000 (T0N1) ❑$25,000 (T0H1)

❑Other: $_____ *in $5,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Spouse Amount (Tobacco User):

❑$100,000 (T0Y5) ❑$50,000 (T0N5) ❑$25,000 (T0H5)

❑Other: $_____ *in $5,000 increments*
(Minimum: $10,000 Maximum: $500,000)

Please select if you wish to include additional options with your coverage *(If AD&D is elected, benefit will match life amount up to a maximum of $500,000)*:

❑ Member Accidental Death & Dismemberment

❑ Spouse Accidental Death & Dismemberment

❑ $10,000 Dependent Child(ren) Coverage*

*If both Member and Spouse are applying, only one can apply for Dependent Child(ren) Coverage.

3. PROVIDE YOUR HEALTH INFORMATION

Member: **Height_____ft. _____in. Weight_____lbs.** Spouse: **Height_____ft. _____in. Weight_____lbs.**

List the name, address and phone number of your regular health care provider and the date you last consulted him or her:

Member :_____ Spouse:_____

_____ _____

	Member	Spouse
1) Have you ever been treated for or been diagnosed by a member of the medical profession as having the HIV infection or AIDS (Acquired Immunodeficiency Syndrome)?	❑ Yes ❑ No	❑ Yes ❑ No
2) Have you ever been diagnosed or treated by a member of the medical profession for:	❑ Yes ❑ No	❑ Yes ❑ No
a. stroke/TIA (Transient Ischemic Attack), sleep apnea, high blood pressure or any disease or disorder of the heart or lungs?	❑ Yes ❑ No	❑ Yes ❑ No
b. cancer/tumor, diabetes, or any disease or disorder of the blood or immune system?	❑ Yes ❑ No	❑ Yes ❑ No
c. seizures, or any disease or disorder of the brain or nervous/mental system (including anxiety, depression and other mood disorders)?	❑ Yes ❑ No	❑ Yes ❑ No
d. arthritis, chronic pain or any disease or disorder of the joint, muscle or neuromuscular systems?	❑ Yes ❑ No	❑ Yes ❑ No
e. disease or disorder of the liver, kidneys or digestive, intestinal, reproductive or urinary systems?		
3) Have you ever received medical treatment or counseling for the use of alcohol or prescribed or non-prescribed drugs, or been advised by a member of the medical profession to discontinue or reduce the use of such substances?	❑ Yes ❑ No	❑ Yes ❑ No
4) Have any of your parents or siblings died prior to age 65 as a result of heart disease, stroke or cancer?	❑ Yes ❑ No	❑ Yes ❑ No
5) Have you in the last three years flown, or do you anticipate flying in an aircraft, other than as a passenger on a scheduled airline?	❑ Yes ❑ No	❑ Yes ❑ No
6) Have you in the last five years had any DUI (driving under the influence) convictions, driver's license suspensions/revocations or moving violations?	❑ Yes ❑ No	❑ Yes ❑ No

a. Member driver's license number and state of issue:_____

b. Spouse's driver's license number and state of issue:_____

PLEASE COMPLETE AND SIGN END OF APPLICATION

3. PROVIDE YOUR HEALTH INFORMATION (continued)

	Member	Spouse
7) Have you ever applied for insurance that was declined, postponed or modified in any way?.....	❑ Yes ❑ No	❑ Yes ❑ No
8) Do you currently have any disorder, condition or disease, or are you currently taking medication prescribed or provided by a member of the medical profession for any disorder, condition or disease not shown above?.....	❑ Yes ❑ No	❑ Yes ❑ No

For every "Yes" answer to questions in the previous section, give details below. Please attach a separate sheet if additional space is needed.

Q#	Applicant	Description of Condition	Date Condition Began	Description of Treatment Received	Health Practitioner Name, Full Address and Phone
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				
	❑ Member ❑ Spouse				

4. DESIGNATE YOUR BENEFICIARY

Include Name, Address, Date of Birth, and Social Security Number for each beneficiary you list below. List the percent each will receive. The total must equal 100 percent. Beneficiary for dependent child(ren) coverage (if elected) will be the insured under the certificate to which the dependent child(ren) coverage is attached. Attach additional sheets if necessary.

Beneficiary for Member Coverage ***(complete this section only if applying for Member coverage on this application)***

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Beneficiary for Spouse Coverage ***(complete this section only if applying for Spouse coverage on this application)***

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

Name (First, Last, MI)				
Date of Birth (MM/DD/YYYY)	Social Security Number	Relationship		Percent
Address	City	State	Zip	Home/Cell Phone #

PLEASE COMPLETE AND SIGN END OF APPLICATION

5. COMPLETE THE FOLLOWING PAYMENT OPTION SECTION

***(Choose only one. Option selected is applicable to all coverages approved through this application)*:**

❑ **Option 1:** **AUTOMATIC CHECK WITHDRAWAL REQUEST:** ❑ Monthly ❑ Quarterly

By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ____ ____ ____ ____ ____ ____ ____ ____ ____ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____**Date:**_____

❑ **Option 2:** **DIRECT BILL:** ❑ Quarterly ❑ Semi-Annual ❑ Annual

Billing dates will begin after coverage is approved and initial premium has been received.

PLEASE COMPLETE AND SIGN END OF APPLICATION

6. READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I have provided is complete and correct.
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company and the first premium is paid in my lifetime.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life Insurance Company.

Authorization and Acknowledgment – Please read and sign below. For underwriting and claim purposes, I give my permission to: Any physician, or any other member of the medical profession, hospital, clinic, other medical or medically related facility, pharmacy, pharmacy benefit manager, insurance or reinsurance company, MIB, Inc. (MIB), Department of Motor Vehicle Records, employer or any other organization or person to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including ChoicePoint or any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery, pharmacy prescriptions or prescription records or any non-medical information, including motor vehicle records, as they apply to any person who is to be covered. I give my permission to ReliaStar Life, or its reinsurers, to make a brief report of personal health information to MIB about these same persons. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about these same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations – 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employer, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it. I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. This form will be valid for 24 months from the date shown below. I acknowledge that I have been given ReliaStar Life's Consumer Privacy Notice.

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Member's Signature (always required)	Date	Spouse's Signature (if applying)	Date

Owner of Member Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (First, Last, MI)		Date of Birth (MM/DD/YYYY)		Social Security Number
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature				Date

Owner of Spouse Certificate (if other than yourself). The owner controls all rights to the Certificate.

Name (First, Last, MI)		Date of Birth (MM/DD/YYYY)		Social Security Number
Address	City	State	Zip	Home/Cell Phone #
Owner's Signature				Date

SEND NO MONEY NOW!

GRPLIFEUW14-ND ReliaStar Life Insurance Company, Minneapolis, MN (07/14)

NOTICE APPLICABLE TO OREGON RESIDENTS

The fraud warning contained on any application/enrollment form contained in this solicitation is not applicable to Oregon residents. The following fraud notice is applicable to Oregon residents only. **Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.**

THIS PAGE IS INTENTIONALLY LEFT BLANK.

ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York
Consumer Privacy Notice and Insurance Information Practices Notice

We are pleased to provide you with information regarding your application or claim. This information is provided to you in accordance with legislation enacted in your state. You may also receive other privacy notices from us or from our affiliated companies. **Please keep this notice and a copy of the completed application or claim form for your records.**

Our Underwriting Procedures

For certain types of coverage, we underwrite your request to determine if you are eligible for the coverage you requested. We review all of the information in the application, and, if necessary, confirm or add to this information in the ways described in this notice. In the event of an adverse underwriting decision, we will provide you with the specific reason for the decision in writing.

Privacy and Information Practices

Collecting Information

Your application or claim form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from MIB, Inc., formerly known as the Medical Information Bureau. See “Notice Regarding MIB, Inc.” below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request.

Notice Regarding Consumer Reports

Insurance companies commonly ask an outside source to verify and add to the information given in an application. Consumer reports are used to help us decide if you are eligible for the insurance you have applied for. The report deals with your mode of living, character, general reputation, and such personal items as your health, job, and finances. It may include information on the following: your marital status, past and present employment record, job duties, driving record, avocation, health history, use of alcohol and drugs, and hazardous sports activities. The agency may get information in these ways: from public records, and by contacting you, members of your family, business associates and employers, financial sources, friends, or others you know. This information will not be used to determine your sexual orientation. You can request that the agency interview you in connection with the preparation of the report. If the report affects your application as requested, we will notify you and provide you with the name and address of the reporting firm.

We use the report only to be sure that each application is evaluated on a fair basis. We will not reveal any of the information we obtain to your friends or associates. We may reveal the information we obtain to other companies or entities affiliated with us. The information may be kept by the consumer reporting agency; it may also later be given to others who have a legitimate need for these reports. It will be given only to the extent permitted by these laws: the Federal Fair Credit Reporting Act as amended by the Consumer Credit Reporting Reform Act of 1996; your state's Fair Credit Reporting Act, if any; or your state's Insurance Information and Privacy Protection Act, if any. If you wish, we will send you the name, address and phone number of any agency we ask to prepare a consumer report about you. The agency will give you a copy of the report if you ask for one and give proper identification.

Information Use

We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure

We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with us or our affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information

If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage or an adverse underwriting decision. Medical information, however, will only be disclosed through the attending licensed physician unless state law provides otherwise. If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone. We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc.

We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB’s file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. MIB’s phone number is 866-692-6901. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

THIS PAGE IS INTENTIONALLY LEFT BLANK.

ROALife
Group Term Life Insurance Plan

ROALife Benefit Notification

As a member in good standing in the Reserve Officers Association of the United States, you can now qualify to apply for ROALife Term Life coverage.

Monthly group rates.

NON-TOBACCO USER									
BENEFIT		**Under 30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**
$ 25,000	Member	$0.95	$1.43	$1.90	$2.85	$5.23	$8.55	$14.02	$20.90
	Spouse[1]	0.72	1.19	1.67	2.38	4.28	7.13	11.88	17.58
$ 50,000	Member	1.90	2.85	3.80	5.70	10.45	17.10	28.03	41.80
	Spouse[1]	1.43	2.38	3.33	4.75	8.55	14.25	23.75	35.15
$100,000	Member	3.80	5.70	7.60	11.40	20.90	34.20	56.07	83.60
	Spouse[1]	2.87	4.77	6.67	9.50	17.10	28.50	47.50	70.30
TOBACCO USER									
BENEFIT		**Under 30**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**
$ 25,000	Member	$0.95	$1.67	$2.14	$3.33	$5.94	$9.74	$16.15	$24.23
	Spouse[1]	0.95	1.19	1.90	2.85	4.99	8.32	13.54	20.19
$ 50,000	Member	1.90	3.33	4.28	6.65	11.88	19.48	32.30	48.45
	Spouse[1]	1.90	2.38	3.80	5.70	9.98	16.63	27.08	40.38
$100,000	Member	3.80	6.67	8.57	13.30	23.77	38.97	64.60	96.90
	Spouse[1]	3.80	4.77	7.60	11.40	19.97	33.27	54.17	80.77

Other benefit amounts are available. Please call administrator for rates.

Premiums are based on your age at date of issue and increase on renewal dates as indicated above. Your rates will not change unless they are changed for all insureds in your classification. Rates shown are guaranteed to 10/31/2020. Your amount of insurance will decrease to 50% on the Group Policy Anniversary date on or after your 70th birthday. Coverage terminates at age 75.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

Qualifications for this ROALife group term life insurance offer are few:

- You must be a Reserve Officers Association member under 60 years of age.
- You must be actively at work.
- You cannot already be insured by this plan.

[1]In Oregon, spouse includes domestic partner.

Coverage as long as you need it

The only way you can lose your coverage is if the entire group policy is terminated, you quit being an ROA member, or you fail to pay your premiums when due. (You can never be singled out and cancelled because of poor health.)

Your ROALife coverage will start on the first day of the month after your application has been approved by the insurer and your first premium has been paid.

(Next page, please)

Accidental Death & Dismemberment Insurance Benefit Option

Group Accidental Death & Dismemberment (AD&D) Insurance can be purchased up to the same level of death benefit being applied for. In addition, many people are seriously injured by accidents and sustain loss of limb or eyesight. For these reasons, the ROA Group Accidental Death & Dismemberment (AD&D) Insurance is an important addition to your benefit plan.

Group Term Life Insurance Underwritten by:
ReliaStar Life Insurance Company
Minneapolis, MN

Policy Form #LP08GP

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Complete details can be found in Group Policy GL-31816-7.

Coverage may not be available to residents of all states. The group policy is sitused in the state of North Dakota and is governed by its laws. This is a paid endorsement. ROA receives a fee from the insurance broker and/or the insurer for its endorsement of this plan.

KEEP THIS INFORMATION WITH YOUR IMPORTANT PAPERS

Administered by:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. BOX 14464
Des Moines, IA 50306-8993

QUESTIONS?
Call: 1-800-247-7988
E-Mail: roa.service@mercer.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC